NHIC

National Heritage Insurance Company
Attn: Provider Enrollment
11044 Research Boulevard, Building C
Austin, Texas 78759-5239

PROVIDER AGREEMENT INSTRUCTION SHEET

Pages 8-1 through 8-9

DUE TO NEW DIRECTION FROM THE TEXAS DEPARTMENT OF HEALTH AND THE TEXAS HEALTH AND HUMAN SERVICES COMMISSION, THE REQUIREMENTS FOR TEXAS MEDICAID PROVIDERS TO COMPLY WITH SENATE BILL 30 (SB 30) HAVE BEEN SIMPLIFIED. TO COMPLY WITH SB 30, PROVIDERS ARE REQUIRED TO COMPLETE ONLY THE PROVIDER AGREEMENT, PAGES 8-1 THROUGH 8-9 OF THE RE-ENROLLMENT PACKET.

If providers desire to do so at this time, they may also complete the rest of the packet now so that NHIC may update their provider files. Otherwise, the state will follow-up with providers about this additional information after September 1, 1999. Please instruct providers to return their entire re-enrollment packet, even if they choose to complete only the Provider Agreement at this time, to NHIC at the address listed above to ensure their compliance with SB 30.

PAGE 8-1

- **Completing the Header Information**
  - **Name of Provider –** This should be the name on file for you in NHIC's provider database**. (REQUIRED)**
  - ***Medicaid Provider ID # -** If re-enrolling for only one number write it in here. If you have multiple Medicaid and/or CIDC provider #s you are re-enrolling you may leave this blank and go to the Addendum Statement on page 8-7 and list all of your Medicaid provider numbers in the block provided. This allows you to complete one agreement for all your numbers by listing them in the Addendum Statement block on page 8-7 (Read page 8-7 instructions also). **(REQUIRED)**
  - **Doing Business As (DBA)** – If you are registered as a DBA (different name than what is written under Provider Name above, list that name here.
  - **Medicare Provider ID # -** Write your Medicare provider ID # here. If you do not have a Medicare provider ID # (example, OB/GYNS, Pediatricians and LPC's are not required to have Medicare #s) write N/A on this line.
  - **Physical Address** – This is the address you should have on file with NHIC where your Medicaid services are being rendered.
  - **Mailing Address** - – This is the address that you should have on file with NHIC to receive any correspondence such as Remittance & Status reports.

PAGE 8-7

- **Completing the Addendum Statement:**
  - **Individual Provider Instructions:**

    If you are an individual provider, you can list every one of your provider numbers on one agreement and sign that agreement for all your provider numbers. This includes group performing provider numbers (example, P08 numbers) and individual billing numbers (example, P000 numbers). If you have only one provider number you are re-enrolling, list that number on the line 'Medicaid Provider ID #' at the top of page 8-1. Next, place N/A in the addendum statement at the bottom of page 8-7, no signature is required in the addendum statement block when using N/A on page 8-7.

PLEASE READ THE ADDITIONAL INSTRUCTIONS ON THE BACK PAGE

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- **Completing the Addendum Statement:**
- **Group Provider Instructions:**

  If you are a group provider, you can list every one of your group's billing provider numbers on one agreement and sign that agreement for all your provider numbers. Performing provider numbers (example, P08 numbers) CANNOT be included with the group's numbers (example, Z000 numbers) in the addendum statement. Every performing provider must sign an agreement in his or her own name. If you have only one group provider number you are re-enrolling, list that number on the line 'Medicaid Provider ID #' at the top of page 8-1. Next, place N/A in the addendum statement at the bottom of page 8-7, no signature is required in the addendum statement block when using N/A on page 8-7.

PAGE 8-8

- **COMPLETING ATTACHMENT I ENTITLED "CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS"**
- Place a ✓ in the appropriate "Yes" or "No" box in answer to the question ***"Do you have or do you anticipate having subcontractors under this proposed contract?"*** located in the middle of the page**. (REQUIRED)**
- Please ✓ the appropriate box located at the bottom of the page above the signature line, which statement applies to the covered potential contractor and/or subcontractor(s). **(REQUIRED)**
- Name of Potential Contractor (this should be the same as the provider name supplied on 8-1).
- Vendor ID No./Employer Tax ID or Social Security No.
- HHSC Contract No. (LEAVE THIS BLANK)
- Signature of Authorized Representative (this signature should be the same that is on 8-7)**. (REQUIRED)**
- Printed Name and Title of Authorized Representative (If you are an individual provider, the response is "Self" or "Provider", If the provider is an entity, for example, a group, hospital, clinic, etc. the response is the person who has signing authority for that entity).

Helpful Tips

- Original signatures are required for all providers.
- The same person should be signing for all signature lines on 8-7 and 8-8.
- Use blue or black ink.
- Signatures by Power of Attorneys, Office Managers, CEOs, etc. will not be accepted for individual providers but may be used as the signing authority' for provider entities such as groups, hospitals, clinics, etc.
- This form does not need to be notarized.

If you have any questions regarding your Senate Bill 30 compliance, or need help completing your application, please call NHIC Customer Service at (512) 343-4900 or 1 (800) 925-9126. Press "1" followed by "#" for Re-Enrollment.